STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

May 3, 2019

Mr. Bimal Patal, Administrator
Hartford Hospital
80 Seymour Street
Hartford, CT 06102

Dear Mr. Patal:

Unannounced visits were made to Hartford Hospital on January 29, February 26, 27, March 19 and April 3, 2019 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, and a certification inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by May 13, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by May 13, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

An office conference has been scheduled for May 28, 2019 at 1:00PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain

DATES OF VISIT: January 29, February 26, 27, March 19 and April 3, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

legal representation, your attorney may accompany you to this meeting. Please be prepared to discuss those violations identified with an asterisk.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:mb

Complaint #24874, 24907, 24818

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D3 (e) Nursing Service (1) and/or (i) General (6).

DATES OF VISIT: January 29, February 26, 27, March 19 and April 3, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. Based on clinical record review and interview for 1 (P#4) of 11 patients reviewed for the use of restraints the facility failed to ensure the patient was assessed according to the frequency identified in the facility policy. The findings include:
   a. Patient #5 was admitted on 1/23/19 for treatment of acute encephalopathy likely to recent surgery and narcotic use, in addition to major depressive disorder. According to the medical record on 1/24/19 at 4:53 PM an order was entered into the medical record for an enclosure/canopy bed for behaviors exhibited by P#5 such as confusion, agitation and restlessness. Alternatives such as 1:1 sitters, bed alarms and redirection were not successful in maintaining a safe environment for P#5.
   According to nursing documentation the canopy/enclosure bed arrived and was initiated on 1/24/19 at 9:00 PM as evidenced by a nursing assessment that identified an assessment of exhibited behaviors, circulation, respiratory status, range of motion and the evaluation of needs such as hygiene, fluid, meals/food and elimination.
   Although the medical record identified on 1/25/19 at 4:55 AM P#5 remains in the canopy/enclosure bed with frequent checks per protocol nursing documentation lacked evidence that P#5 was assessed for exhibited behaviors, circulation, respiratory status, range of motion and the evaluation of needs such as hygiene, fluid, meals/food and elimination on 1/24/19 at 11:00 PM and 1/ 25/19 at 1:00 AM, 3:00 AM and 5:00 AM.
   During an interview and review of the medical record with the Unit Manager and Charge Nurse on 1/29/19 at 9:00 AM they indicated P#5 should have been assessed every 2 hours while in the canopy/enclosure bed and the medical record lacked those assessments as identified.
   Hospital Restraint/Seclusion policy indicated for the use of non-violent or non-self-destructive restraints a nursing assessment is to be completed and documented every 2 hours. The assessment should include proper application of the restraint, signs of injury, physical and psychological status, hygiene, food and fluid needs, adequate circulation, range of motion, movement feeling of touch and skin integrity.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (i) General (6).

2. *Based on a review of clinical records, interviews, and policy review for one (1) of ten (10) patients reviewed for care and services (Patient #15), the facility failed to ensure that an allegation of abuse was immediately and/or thoroughly investigated and/or that the patient was free from abuse. The finding includes the following:
   a. Patient #15 was admitted on 1/9/19 with ventricular premature depolarization. The patient had a deep intraseptal paraHIsian PVC ablation completed followed by a dual chamber pacemaker implant.
   Interview with RN #16 on 2/26/18 at 2:30 PM indicated that on 1/9/19 he was in the control room in the Electrophysiology (EP) lab and saw MD #15 with his hands raised to head/chest level and then MD #15 slammed his hands down on the mid abdomen of the patient. RN #16 indicated that the patient moaned.
   Interview with RN #15 on 2/26/19 at 1:30 PM indicated that on 1/9/19 she had stepped out

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

of the EP room and on her return to the control room heard a moan and asked RN #16 and 17 what the noise was, and was informed that MD #15 had just slammed his hands down on the patient and the noise was the patient moaning.

Interview with RN #17 on 2/27/19 at 10:45 AM indicated that on 1/9/19 he was in the control room of the EP lab and witnessed MD #15 slam both hands down on the magnetic mat which was on the patients abdominal area.

Interview with Scrub Tech #15 indicated that she was in the room with MD #15. ST #15 indicated that during the procedure MD #15 was holding the sheath cupped in his hands and lowered his hands to the magnetic mat. ST #15 indicated that the patient moaned.

Interview with MD #15 on 3/19/19 at 10:20 AM indicated that on 1/9/19 he performed an ablation and pacemaker insertion on Patient #15. MD #15 stated the procedure had been very lengthy and after finishing the ablation portion of the procedure, when the patient was awake, the next step was to place the patient in conscious sedation and perform the pace maker insertion. MD #15 stated that he was having a difficult time placing the guidewire and had been trying for a period of time when he realized it was not going to work. MD #15 removed the wire and sheath with two hands with the guidewire between his thumb and forefinger and upon removal, placed the sheath down with emphasis on the magnetic mat which was on the patient. MD #15 indicated that the patient grunted and the physician responded that he did not know the patient was awake. Patient #15 responded that he/she had been awake the entire time. MD #15 indicated that the patient never raised a concern or complaint following the incident. MD #15 indicated that there was no intent to harm the patient.

Interview with the Vice President of Medical Affairs (VPMA) on 2/26/19 at 12:30 PM indicated that he was notified that an internal complaint was filed regarding MD #15 and he interpreted the concern as a practitioner issue and not abuse, therefore, forwarded the concern to the Chief of Cardiology and the Chief of Electrophysiology. The VPMA indicated that no further follow-up had occurred and that the ball had been dropped.

Interview with the Chief of Electrophysiology on 2/28/19 at 2:50 PM identified that he was notified on the morning of 1/10/19 that there was a Quantros report (anonymous internal computerized reporting mechanism) regarding MD #15. He made an appointment with MD #15 for 1/15/19. At that meeting, MD #15 was notified that his reported behavior of slamming his hands down on Patient #15 was unprofessional. Another meeting with MD #15 occurred approximately two weeks later where professional behaviors were discussed.

Interview with the Chief of Cardiology on 2/26/19 at 1:11 PM identified that he met with MD #15 on 1/15/19 and discussed the incident. The Chief of Cardiology identified that he was in the process of stepping down as the Chief and thought that the in-coming Chief would be responsible for follow-up.

On 2/26/19 MD #15 voluntarily relinquished privileges at the hospital.

Review of the Medical Staff Professionalism policy failed to identify immediate actions that should occur when allegations of physical abuse are made.

Review of the Medical Staff Professionalism policy indicated communication, collegiality and collaboration are essential for the provision of safe and competent patient care. As such, all practitioners must treat others with respect, courtesy and dignity and conduct themselves in a professional cooperative manner.

DATES OF VISIT: January 29, February 26, 27, March 19 and April 3, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section19-13-D3 (e) Nursing Service (1) and/or (i) General (6).

3. Based on a review of clinical records, interview, and policy review, for two (2) of three (3) patients reviewed who utilized restraints (Patient #24 and #25), the facility failed to ensure that an assessment was conducted that warranted the use of restraints. The findings include the following:
   a. Patient #24 was admitted on 4/1/19 with an inventricular tumor. Review of a physician's order dated 4/2/19 at 5:07 PM directed the use of bilateral wrist restraints for risk for self-injury. Review of the clinical record with the Informatics RN indicated that although the patient was monitored every two hours, the record failed to reflect an assessment that warranted the use of restraints.
   b. Patient #25 was admitted to the hospital on 4/2/19 after a motor vehicle accident. The physician's order dated 4/2/19 at 6:24 PM directed the use of bilateral wrist restraints. Review of the record with the informatics RN and the Regulatory Director failed to reflect an assessment that warranted the use of restraints.
   Review of the Restraint and Seclusion Policy indicated that comprehensive assessments and reassessments should be documented in the clinical record and include in part, the following, the patient's condition, symptoms, interventions, alternatives attempted, and clinical justification (reason or behavior requiring the restraint), least restrictive devise tried and patient's response.

The following is a violation of the Regulations of Connecticut State Agencies Section19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (i) General (6).

4. *Based on a review of the clinical record, interviews, and policy review, the facility failed to ensure that a mechanism was in place to ensure that a comprehensive investigation was completed after an allegation of patient abuse was made. The finding includes the following:
   a. Patient #15 was admitted on 1/9/19 with ventricular premature depolarization. The patient had a deep intraseptal paraHIsian PVC ablation completed followed by a dual chamber pacemaker implant.
   Interview with RN #16 on 2/26/18 at 2:30 PM indicated that on 1/9/19 he was in the control room in the Electrophysiology lab (EP) and saw MD #15 with his hands raised to head/chest level and then MD #15 slammed his hands down on the mid abdomen of the patient. RN #16 indicated that the patient moaned. RN #16 indicated that no one has interviewed him about the incident.
   Interview with RN #15 on 2/26/19 at 1:30 PM indicated that on 1/9/19 she had stepped out of the EP room and on her return to the control room heard a moan and asked RN #16 and #17 what the noise was, and was informed that MD #15 had just slammed his hands down on the patient and the noise was the patient moaning.
   Interview with RN #17 on 2/27/19 at 10:45 AM indicated that on 1/9/19 he was in the control room of the EP lab and witnessed MD #15 slam both hands down on the magnetic mat which was on Patient #15's abdominal area. RN #17 stated that no one has interviewed

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

him about what happened on 1/9/19.

Interview with the EP Manager on 2/26/19 at 2:00 PM indicated on 1/10/19 he received a copy of an internal report staff had filed about an incident that happened on 1/9/19 that indicated that MD #15 slammed his hands on Patient #15's abdominal area. The Manager indicated that he talked to several staff about the incident and staff reported consistent stories. However, the manager did not conduct and/or document interviews or statements.

Interview with Scrub Tech (ST) #15 indicated that she was in the room with MD #15. ST #15 indicated that during the procedure MD #15 was holding the sheath cupped in his hands and lowered his hands to the magnetic mat and the patient moaned. ST #15 indicated that no one ever interviewed her about exactly what happened.

Interview with the Assistant Manager of the EP lab on 2/26/19 at 11:50 AM indicated that the incident was reported to her on 1/10/19 by RN #17 and she spoke with him and CST #15 about the incident but did not conduct and/or document interviews or statements.

Interview with the Vice President of Medical Affairs (VPMA) on 2/26/19 at 12:30 PM indicated that the report of the incident had been forwarded to him and he had forwarded it to the Chief of Cardiology and the Chief of Electrophysiology. The VPMA indicated that after that no further follow-up had occurred and that the ball had been dropped. Additionally, the VPMA identified that if there was an issue with patient safety or if a patient was harmed, the incident would be referred to the quality department, but in this case, it was not.

Interview with the Director of Regulatory Readiness on 2/26/19 at 12:10 PM indicated that staff are able to file anonymous reports via the computer system and these are reviewed daily to determine follow-up. In this case, the report was sent to the VPMA for review.

Review of the Medical Staff Professionalism policy indicated communication, collegiality and collaboration are essential for the provision of safe and competent patient care. As such, all practitioners must treat others with respect, courtesy and dignity and conduct themselves in a professional cooperative manner. Review of Medical Staff Professionalism policy indicated that based on interviews, discussions and consultations with medical staff leaders the VPMA will determine the next course of action. Additionally the policy failed to reflect time requirements when conducting the investigation.